The

New Brunswick

Community Health Centers

Framework

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Department of Health and Wellness
New Brunswick

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This framework for Community Health Centers in New Brunswick is intended primarily for use by the Community Health Centers, Regional Health Authorities, and the Department of Health and Wellness. This framework is not intended to be prescriptive, but rather a resource that can be used to address the unique and individual health needs of your community.

As a guideline this document can help us work together to improve the health of New Brunswickers.

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1. INTRODUCTION

Community Health Centers (CHCs) are organizations that provide Primary Health Care (PHC) services, Illness/Injury Prevention, Chronic Disease Management and Community Development services, using a Population Health Promotion (PHP) approach in a Multidisciplinary Team of health providers. These teams often include physicians, nurse practitioners, social workers, dietitians, health promoters, counselors and others health-care providers.

The health of a community is maximized through a partnership, which combines the skills, knowledge of life experience/expertise of individuals and community with those of the service providers. All service providers have a responsibility to the community to share information and knowledge that facilitates informed decision-making.

The Health System Renewal is based on the following fundamental concepts.

QUALITY HEALTH
A quality health system is one that provides the right care at the right time in the right way by the right person.

WELLNESS
More than focusing on just illness, the health system focuses on the wellness of individuals, families and communities. New Brunswickers have access to preventative measures and programs. They also have access to health and wellness education that promotes responsible life choices and healthy, active lives.

PATIENT FOCUSED/RESPONSIVE TO INDIVIDUAL NEEDS
The health system is concerned with the individual as a whole person. People are able to make informed choices and participate in decisions regarding their personal health care.

AFFORDABLE
A sustainable health system for the future is an affordable one. The New Brunswick health system must look at alternatives to increased spending in an attempt to renew the system. The Health system should be based on an affordable, long-term plan.

SUSTAINABLE
The health system will continue to be available and affordable to all New Brunswickers for many years to come. The system will continue to provide high quality service and invest in and encourage innovation and continuous improvement.

INTEGRATED
The health system is designed to follow the person's needs, not the other way around. Health professionals collaborate to serve the person's individual needs. Service responsibilities and delivery are appropriately organized at each level to meet the individual's needs.

COMMUNITY FOCUSED
Primary Health Care services are available at the community level. New Brunswickers have equitable access to services. Each community participates in decisions affecting health services and programs.

ACCESSIBLE
The health system responds to family and work reality by offering flexible hours of operation based on the individual community needs. The roles and responsibilities of health providers are adaptable to patient needs.

ACCOUNTABLE
The health system informs New Brunswickers about what is happening and the level to which health quality standards are being attained. The results of this monitoring and reporting will help to influence and direct policies and programs. The system remains accountable to those who ultimately pay for the service – the taxpayer.

SHARED RESPONSIBILITY
The health system is something each of us has a stake in. New Brunswickers must understand what services and results to expect of the health system. They also will understand their own personal responsibility to make healthy choices for themselves and for their communities to ensure a sustainable health system.

RESPECTFUL OF NEW BRUNSWICK'S DIVERSITY
The health system is structured to respect community and individual differences. New Brunswickers are treated with dignity and compassion. Cultural, lifestyle and linguistic differences are respected.

1.1 VALUE STATEMENT

We value and take pride in the shared responsibility with citizens to nurture our community and our corporate well being. We strive to respect the dignity of all persons, and to support the welfare and growth of all individuals.

We will work towards the prevention of illness and injury by assisting people to be responsible for achieving their own healthy body, mind, environment, relationships and community.

We value healthy outcomes for the community through achieving a responsive primary health care system that meets the needs of our citizens and community.

We will respond appropriately to government requirements and position ourselves to be an effective primary health care provider.

We value the professionalism and expertise of our staff who recognize client rights and client confidentiality as paramount. We also acknowledge our staff as the most valuable asset and will encourage on going professional development and teamwork

We value being recognized as a provider of high quality accessible holistic community based health care and we value being part of a diverse, healthy and equitable community.

1.2 Purpose

The motivation for promoting health goes far beyond the possibility of saving money. It is about reducing unnecessary suffering and enabling people to live longer, fuller, happier lives. Population Health Promotion is about creating the conditions that support the best possible health for everyone. Population Health Promotion strengthens the skills and capacities of individuals, groups, and organizations to address the underlying social and economic conditions and physical environments that affect health. PHP is carried out by and with people, not provided to people. People cannot be healthy unless they have control over their lives. We need to create environments in which individuals and communities are empowered to transform their lives and achieve a higher level of wellness.

One of the goals of health reform is to broaden and balance the health care system's focus between sick and restorative care "service delivery" and a Population Health Promotion approach, in which the system's primary goal is the enhancement of health at the individual and population levels. In keeping with the participatory approach of PHP, it is essential that the community be involved in the process of setting health priorities.

1.3 Background and Rationale

Community Health Centers have emerged in Canada as a model of service delivery and health care management that is based on the principles of Primary Health Care. CHCs have been in existence in Canada since 1920. Their services are designed to meet the specific health needs of a defined community or population. In many communities, CHCs provide their programs and services for people who have difficulty accessing a full range of appropriate Primary Health Care services. Some examples of priority groups are members of linguistic or cultural groups, individuals who are homeless, and the elderly.

It is recognized that many other factors, beyond personal behaviors, have a powerful effect on health in particular, the social environment, including socioeconomic status, social network, and working conditions. CHCs provide a wide variety of population health promotion and illness/injury prevention services, chronic disease management which focus on addressing and raising awareness of the broader determinants of health such as employment, education, environment, isolation and poverty.
The New Brunswick government views CHCs as an important component in achieving its vision for health care: "*a single integrated patient focused community based health services system for New Brunswickers.*"

The establishment of CHCs was recommended by the New Brunswick Premier's Health Quality Council, as a means of enhancing local access to Primary Health Care services through a network of CHCs, designed to provide and coordinate, where feasible, all Primary Health Care services.

CHCs are vehicles for health promotion, including health education, individual advocacy, community development, social action, building healthy public policy, and creating supportive environments. All of these components need to be present to optimize the health of the community. The primary role of the CHC is to support the community in meeting its health goals.

2 OBJECTIVES OF DEVELOPING CHCs IN NEW BRUNSWICK

The Objectives for developing Community Health Centres in New Brunswick are:

- To enhance timely and appropriate access to primary health care services
- To ensure a strengthened role for the individual, family and community in health and health care delivery
- To develop linkages and collaboration among health services and with social and other community services
- To offer a comprehensive range of affordable and reliable primary health care services to a defined population based on their health needs
- To enhance the health status of communities through an increased emphasis on health promotion, disease and injury prevention and the management of chronic diseases in the community
- To establish an interdisciplinary approach to the delivery of primary health care services so that the most appropriate service is provided by the most appropriate provider

3 CHC SERVICE DELIVERY MODEL

3.1 CHC Governance

The CHC's while governed by the Board of Directors of its local RHA, requires the active participation and involvement of the constituency it serves. RHAs are responsible to establish mechanisms that actively involve citizens served by the CHC in the planning, delivery, and evaluation of CHC services.

3.2 Service Population

CHCs will offer a range of comprehensive Primary Health Care services in diverse communities across New Brunswick based on community health needs to all clients within a defined population. However, clients without a family physician will be given priority access to medical services.

A Community Health Needs Assessment Framework/guideline is available from the DHW to assist in determining population needs and service priorities.

This Framework for the Community Health Needs Assessment process is intended to guide both the community members and the staff through an assessment process that will help them identify the communities' health concerns and existing resources/services or assets.

3.3 Guiding Principles for CHCs

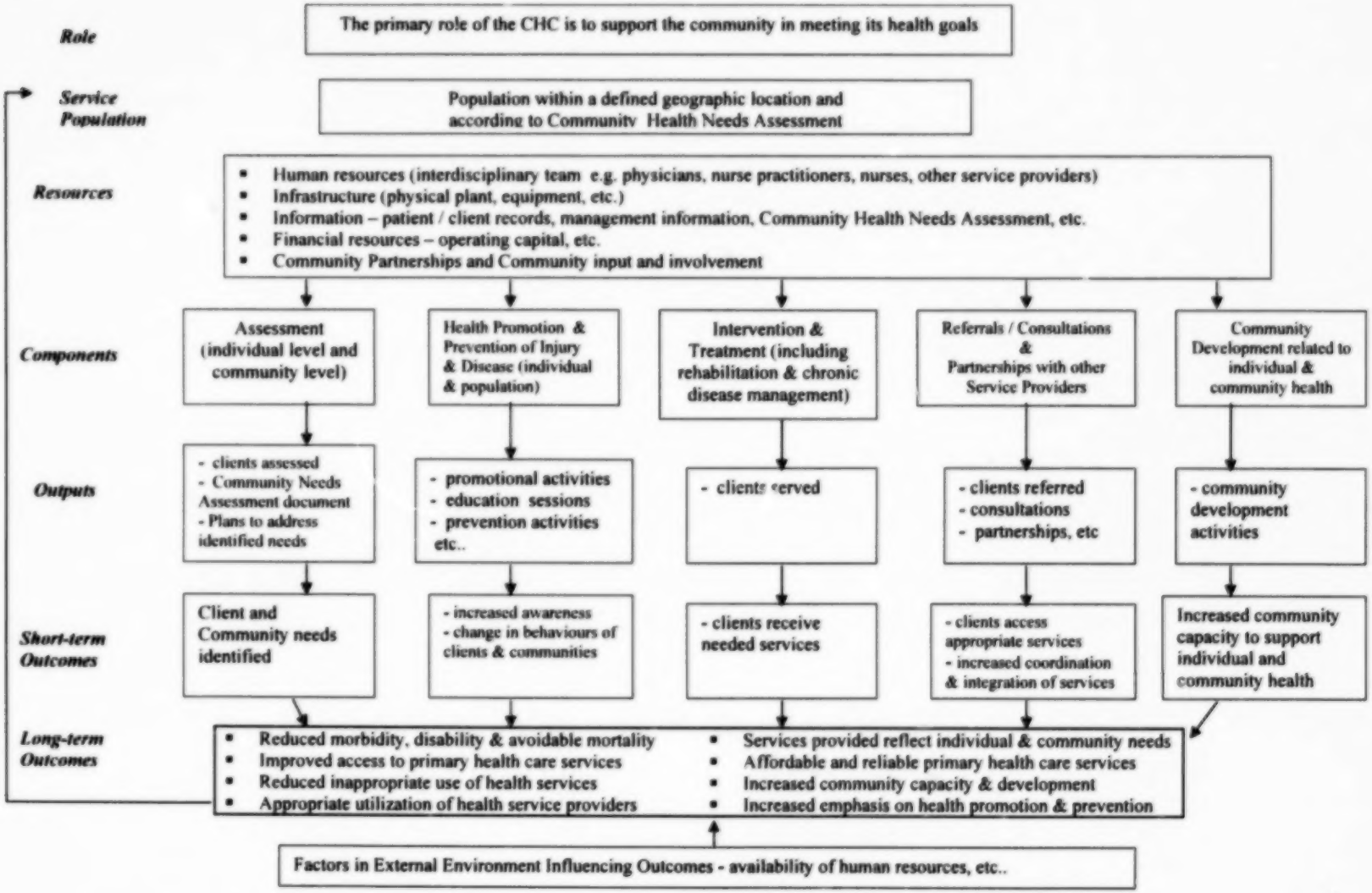
While the program focus may vary among CHCs, all centers will subscribe to the following principles:

- CHCs provide accessible Primary Health Care services that are culturally and linguistically appropriate.
- CHCs support individuals and communities in taking responsibility for and control of their own health and health care.
- Collaboration, Partnership and Linkages with other services and sectors in the community enhance opportunities for positive health outcomes.
- CHCs' focus on outcomes and evidenced-based best practice delivered through inter-disciplinary model of services.
- Existing community infrastructure provides a base upon which services and supports can be built.
- Community participation in decision-making is valued and supported.

3.4 Conceptual Model for Service Delivery through CHCs

The Conceptual Model presented below identifies the key components of the CHC Service Delivery Model and provides some examples of outputs and outcomes expected to be achieved.

Conceptual Model of Proposed Community Health Centers for New Brunswick


Role
The primary role of the CHC is to support the community in meeting its health goals
Service Population
Population within a defined geographic location and according to Community Health Needs Assessment
Resources
Human resources (interdisciplinary team e.g. physicians, nurse practitioners, nurses, other service providers)
Infrastructure (physical plant, equipment, etc.)
Information – patient / client records, management information, Community Health Needs Assessment, etc.
Financial resources – operating capital, etc.
Community Partnerships and Community input and involvement
Components
Assessment (individual level and community level)
Health Promotion & Prevention of Injury & Disease (individual & population)
Intervention & Treatment (including rehabilitation & chronic disease management)
Referrals / Consultations & Partnerships with other Service Providers
Community Development related to individual & community health
Outputs
- clients assessed
- Community Needs Assessment document
- Plans to address identified needs
- promotional activities
- education sessions
- prevention activities etc..
- clients served
- clients referred
- consultations
- partnerships, etc
- community development activities
Short-term Outcomes
Client and Community needs identified
- increased awareness
- change in behaviours of clients & communities
- clients receive needed services
- clients access appropriate services
- increased coordination & integration of services
Increased community capacity to support individual and community health
Long-term Outcomes
Reduced morbidity, disability & avoidable mortality
Improved access to primary health care services
Reduced inappropriate use of health services
Appropriate utilization of health service providers
Services provided reflect individual & community needs
Affordable and reliable primary health care services
Increased community capacity & development
Increased emphasis on health promotion & prevention
Factors in External Environment Influencing Outcomes - availability of human resources, etc..

3.5 Operational Requirements of CHCs

3.5.1 Community Health Needs Assessment (CHNA)

A healthy community is more than just a goal: it is a process in which each community decides its health issues and develops its own response.

Conducting a CHNA will start the community on the path of wellness by identifying resources (assets) in the community and matching these assets to health concerns (needs) the community identifies. In this way, the community can guide the direction of health services to better serve the health concerns (needs) of the community.

A CHNA involves systematically collecting and analyzing information about health. The goal of this process is to encourage public and community participation and to provide Regional Health Authorities with the necessary information to identify their communities' health issues/concerns (needs) and existing resources (assets) in order to establish priorities for the development of programs or services.

The overall goal is to arrive at a prioritized list of health concerns (needs) that would inform decision-makers regarding the allocation of health resources. Professional resources are available to CHC's and would be identified by the outcome of the community health need assessment.

The RHA will need to initiate a CHNA process with the community in which the CHC is being established. This CHNA process will provide an ongoing mechanism through which the RHA can:

- Gather information about the health concerns (needs) of the community and of individuals within the community.
- Gather information about resources (assets) within the community which support individual and community health (i.e. the community's health assets)
- Determine what issues are most important to address within the community.
- Work towards empowerment through assisting people to gain greater control over decisions and actions affecting their health.
- Work towards public participation in the development, implementation, and evaluation of policies, programs and services.
- Work towards intersectoral collaboration through the formation of partnerships and collaboration among the public sector, civil society and the private sector.
- Build commitment, supports and relationships with members of the community towards working on addressing the identified health needs of the community.

3.5.2 Accessibility of Services

CHCs shall establish hours of operation that are responsive to community needs.

3.5.3 Record Management

CHCs shall create, maintain, protect, retain and destroy records for each client receiving services at the CHC in a confidential manner consistent with the legislation.

3.5.4 Quality Assurance and Risk Management

RHAs shall ensure that the CHCs have appropriate mechanisms for quality assurance and risk management.

3.6 Funding

CHCs will be funded based on community needs and on the facilities and resources available. Funds available for CHC will be determined between DHW and RHA.

3.7 Accountability and Reporting by CHCs

The CHCs will have multiple stakeholders to whom they will be accountable, including their communities, the RHAs, the Department of Health and Wellness. To help address their accountability requirements, the following two important components will need to be considered.

3.7.1 Ongoing Performance Measurement

The CHCs will need to establish a process to assess and monitor their performance and success in achieving their goals. This process must include developing and maintaining indicators related to their performance and regularly reporting to their stakeholders. Indicators should be developed through a consultative process involving the CHCs, the RHAs, and the DHW and will need to reflect and be congruent with work currently underway in relation to performance measurement. These indicators must also address any reporting requirements of the DHW related to the Primary Health Care Transition Fund.

3.7.2 Evaluation

A formative (process) evaluation will need to be conducted within two years of the implementation of the CHCs for the purpose of assessing how the CHCs are being implemented, whether adjustments are necessary and whether progress is

being made toward the achievement of the stated goals and objectives. This evaluation will provide an opportunity to identify lessons learned and to assess if any negative impacts are being experienced as a result of the implementation of the CHCs. The evaluation will also need to support addressing the reporting requirements of the DHW related to the Primary Health Care Transition Fund.

4 Conclusion

The shift toward a more collaborative approach to Primary Health Care encourages all parties to reflect and learn. It promotes a focus on common ground and recognizes that citizens and communities have important knowledge and experience to add to the decision making process.

Primary health care is the first level of contact with the health care system, bringing health care as close as possible to where people live, learn, work, play and pray, and constitutes the first element of a continuing care process.

CHCs are designed to improve access to Primary Health Care services and help focus efforts on population health promotion, chronic disease management, and the prevention of illness and injury through strengthening interdisciplinary teamwork and partnering with communities.

Finally, primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community and country can afford.

Appendix - I - Definitions

1. **Community**
   A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, and are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms that have been developed by the community in the past, and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them.

   In many societies, particularly those in developed countries, individuals do not belong to a single, distinct community, but rather maintain membership of a range of communities based on variables such as geography, occupation, social and leisure interests.

2. **Community action for health**
   Refers to collective efforts by communities, which are directed towards increasing community control over the determinants of health, and thereby improving health.

3. **Determinants of health**
   The range of personal, social, economic and environmental factors which determines the health status of individuals or populations.

4. **Empowerment**
   Having the power to determine one's own needs and the resources to make informed choices.

   In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health.

5. **Equity**
   Equity means fairness. Equity in health means that people's needs guide the distribution of opportunities for wellbeing. This implies that all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health.

   Equity in health is not the same as equality in health status. Inequalities in health status between the individuals and populations are inevitable consequences of genetic differences, of different social and economic conditions, or a result of personal lifestyle choice. Inequities occur as a consequence of differences in opportunity which result, for example in unequal access to health services, to nutritious food, adequate housing and so on. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life.

Equity is concerned with creating equal opportunities for health and bringing health differentials down to the lowest level possible.

6. **Health**
   Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. It is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs and, on the other hand, to change or cope with the environment.

   Health is a dynamic process involving the harmony of physical, mental, emotional, social and spiritual wellbeing. It enables individuals, families and communities to function to the best of their ability within their environment.

7. **Health promotion**
   Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health.

   Health promotion is not just about pamphlets and posters. It includes education, training, research, and community development.

   Health promotion is a group effort. It requires the coordinated action of national, provincial and local governments, industry, service providers, voluntary organizations and people from all walks of life. Health, therefore, is not solely the responsibility of the health department but of all people, governments, industries, social institutions, communities, families and friends.

8. **Intersectoral collaboration**
   Intersectoral collaboration is a recognized relationship between different sectors or between parts of different sectors of society. This collaboration has been formed to take action on an issue to achieve a common goal in a way, which is more effective, efficient or sustainable than might be achieved by the health sector being alone.

   Intersectoral refers to the inter-relationship among all sectors or parts of society. An intersectoral approach means involving representatives from a wide variety of groups such as governments, business, labour, health, education, environment, agriculture and other agencies and interests.

9. **Partnerships for health promotion**
   A voluntary agreement between two or more partners to work co-operatively towards a set of shared health outcomes. Such partnerships may be limited by the pursuit of a clearly defined goal or may be ongoing, covering a broad range of issues and initiatives. Increasingly, health promotion is exploring partnerships between the public sector, civil society and the private sector.

10. Population health

Population health is an approach that addresses the entire range of factors that determine health and, by so doing, affects the health of the entire population.

11. Population health promotion

A recently introduced Canadian term that builds on the complementarity of health promotion and population health. It is represented by Health Canada's Population Health Promotion model, which shows how a population health approach can be implemented through action on the full range of health determinants by means of health promotion strategies.

12. Primary health care

It is the first level of contact of individuals, the family and community with the health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process and may include: health education, promotion and prevention at individual/community level, assessment, diagnostics and intervention/treatment.

"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health care system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process." (WHO, Alma Ata Declaration, September 12, 1972)

13. Public participation

Public or community participation is the active participation of people living together in some form of community in the process of problem definition, decision-making and action to promote health.

14. Supportive environments

Supportive environments for health offer people protection from threats to health, and enable people to expand their capabilities and develop self reliance in health. They encompass where people live, their local community, their home, where they work and play, including people's access to resources for health, and opportunities for empowerment.

15. Assessment

An assessment is defined as a process of gathering information for the purpose of identifying needs.

16. Assets

Assets are the resources found within any community. Assets can be *physical resources* (budgets, grants, funding alternatives), *people-based resources* (local organizations, volunteer groups, private business, government), or *individual resources* (personal skills, experience, capacities, gifts).

17. Indicators

Indicators are criteria that help you understand where you are, which way you are going and how far you are from where you want to be. Indicators are measurable and can be verified by objective observation.

18. Needs

Needs are defined as problems, not solutions or wants. Needs may be:

- problems to be solved;
- gaps to be filled; and
- Things to be improved.

19. Demographics

Statistical study of people with reference to vital statistics (e.g. births, marriages, deaths, etc.), housing, education income, social patterns/values, etc.

20. Framework

Model or frame of reference to guide the collection and interpretation of data, or the development of policy; identifies major elements to be considered in assessing the health needs of the population.

21. Meaningful participation

An identified percentage of the population (e.g. 1%) is approached for comment; opportunities are provided where people feel comfortable to speak out on issues of concern to them; process is responsive.

22. Service provider

Service providers include health professionals, para-professionals, alternative therapists, self-help groups and volunteers providing services to district residents.

23. Vision

A statement of the preferred future in the context of the mandate of the organization; how the Board would like to influence the health of the population and the services they would like to provide or recommend to support health.